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Department of
Veterans Affairs

Geriatrics and Extended Care
Hospital Based Home Care

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CHAPTER 1. HBHC (HOSPITAL BASED HOME CARE) PROGRAM

1.01 LEGAL AUTHORITY

38 CFR Part 17, Section 17.60 (j), authorizes:

Home health services may be furnished to an eligible veteran when such services are found to be necessary or appropriate for the effective and economical treatment of the veteran's disability.

1.02 AUTHORITY AND RESPONSIBILITY

a. The VA medical center Director has the overall responsibility for the HBHC program and appoints and delegates the authority and responsibility for the day-to-day operations of the HBHC program to the HBHC Program Director.

b. The VA medical center Chief of Staff is responsible for all professional programs, including HBHC. The HBHC Program Director, a qualified health care professional, is accountable to the Chief of Staff for the overall administration and quality of care provided by the HBHC program. The Chief of Staff will appoint the HBHC Medical Director. This physician is responsible for the medical care delivered by the HBHC Team.

c. HBHC is an outpatient medical program which should be under the direction of the Associate Chief of Staff for Extended Care, if such a position exists at the facility. In some VA medical centers, HBHC functions effectively under the Chief of Staff, the Associate Chief of Staff for Ambulatory Care or the Chief of Medical Service.

1.03 ACCREDITATION STANDARDS

All HBHC programs are required to meet the JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Home Care Standards for Accreditation.

1.04 DEFINITIONS

a. HBHC (Hospital Based Home Care) is a program which delivers primary health care in the home, through a VA hospital based interdisciplinary team, to homebound and often bedridden eligible veterans whose caregivers are capable and willing to assist in their care.

b. HBHC is a direct care program, administered from a VA health care facility, that utilizes VA personnel and resources. It is an outpatient program providing health services to individuals who require continuing care and for whom follow-up in an outpatient clinic is not feasible.

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c. Homebound is considered to be the normal inability to leave home because of any one of the following situations:

(1) Requires the assistance of another individual.

(2) Requires the aid of a supportive device.

(3) Leaving home is medically contraindicated.

(4) Requires a considerable and taxing effort.

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(5) Leaves home only for short duration and infrequently.

(6) Leaves home only for medical care.

d. Caregiver is defined as a person related to or associated with the veteran who performs, assists and/or lends support in the care of the patient.

1.05 OBJECTIVES OF THE HBHC PROGRAM

a. To provide primary health care services to homebound and often bedridden patients who reside in the community. This primary health care is defined as accessible, comprehensive, coordinated, continual, accountable and acceptable as follows:

(1) Accessibility. Means the HBHC patient/caregiver has access to the providers of care and explicit provisions have been made for emergencies during the night, on weekends, and on holidays.

(2) Comprehensiveness. Means the HBHC team is able to treat and manage the majority of health problems arising in the HBHC population, and provide preventative maintenance services.

(3) Coordination. Means the HBHC team coordinates the patient's care by referring patients to the appropriate specialists, providing pertinent information to and seeking opinions from these specialists, and explaining and teaching diagnosis and treatment to the patients and caregivers.

(4) Continuity. Means regular visits from the HBHC team and maintenance of complete medical records which are regularly reviewed and used in planning care.

(5) Accountability. Means that the HBHC team will develop a quality management program which monitors and evaluates the services that the team renders. The goal is to work toward continuous improvement. HBHC services will meet all applicable home care standards and its quality management program will fully integrate with those of the medical center.

(6) Acceptability. Means the HBHC patient and home caregiver agree to receive HBHC services and participate in the development of the treatment plan.

b. To create a therapeutic and safe environment in the home.

c. To support the home caregiver in the care of the patient.

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d. To reduce the need for, and provide an acceptable alternative to hospitalization, nursing home care, emergency room and other outpatient clinic visits.

e. To promote timely discharge from the hospital or nursing home.

f. To provide an academic and clinical setting for students of the health professions in the interdisciplinary delivery of primary care to a chronically ill long-term care population in the home.

1.06 PHILOSOPHY OF CARE

a. HBHC is designed to be an extended care program to meet the long-term care needs of an aging veteran population. In contrast to the time-limited skilled care services

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reimbursed by other funding mechanisms such as Medicare, HBHC provides comprehensive long-term care of the patient. While the veteran is in the HBHC program, the veteran's care is managed through a combination of providing and arranging for all health services. Attention should be paid to the provision of services in a cost efficient manner.

b. HBHC care is best rendered by an interdisciplinary team to effectively assess and manage the multiple, interacting health problems of chronic or terminally ill patients. The team provides primary health care to the patient while supporting and teaching the home caregiver to care for the patient. The unit of care, therefore, is the patient and the caregiver.

1.07 SCOPE AND PURPOSE OF CARE

The HBHC program provides primary health care to three main types of homebound veteran patients in the home setting. The three main types of patients appropriate for HBHC services and the related purposes of care are:

a. Long-term care patients (e.g., patients with chronic, multiple, interacting medical and psychosocial problems). Purpose of care:

(1) To offer families an alternative to nursing home placement.

(2) To minimize the amount of follow-up by Ambulatory Care Clinics.

(3) To prevent premature admissions to long-term care institutions.

(4) To maintain optimal physical, cognitive and psycho-social functioning.

b. Patients with terminal illnesses (e.g., palliative care patients). Purpose of care:

(1) To allow the patient the option of dying at home rather than in an institution.

(2) To help the patient and family cope with imminent death.

(3) To manage pain and other symptoms.

(4) To provide bereavement care to the family following the death of the patient.

c. Short-term care patients (e.g., patients needing post-hospital rehabilitation, or monitoring). Purpose of care:

(1) To assist in the transition from institution to home.

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(2) To provide close monitoring of the patient.

(3) To provide intensive patient/caregiver education.

(4) To adapt and optimize rehabilitation to the home environment.

1.08 RELATIONSHIP TO OTHER EXTENDED CARE PROGRAMS

The HBHC program, as a specific level of long-term care, is able to provide continuity in therapeutic interventions for patients discharged to their own homes from inpatient care or other Extended Care Programs. HBHC serves as a discharge resource

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for eligible patients from the GEM (Geriatric Evaluation and Management program), NHCU (Nursing Home Care Unit), CNH (Contract Nursing Home), inpatient hospice units, and ADHC(Adult Day Health Care) programs. HBHC is able to deliver primary health care to selected patients placed in CRC (Community Residential Care) and also trains CRC sponsor's staff in specific procedures. The Respite Care program is frequently accessed for HBHC patients to enable the family to continue in their caregiving responsibilities. The HBHC team works collaboratively with the staff of the various extended care programs in securing patient care information and promoting transfers between the programs to assure placement of the patient in the most appropriate level of care.

1.09 TEACHING PROGRAM

a. The HBHC program provides an unique educational experience for fellows, residents, and students of various health professions. Medical, nursing, social work, dietetics, pharmacy and rehabilitation therapy trainees are taught interdisciplinary assessment, treatment plan development, and, most of all, primary care of a chronically ill patient population in a home setting. The HBHC program provides the trainee with the opportunity to observe and participate in an interdisciplinary team as well as to experience first-hand the major care issues of this country's aging population.

b. The HBHC Program Director and Medical Director are encouraged to seek educational affiliations with the various professional schools through the promotion of the HBHC program's training opportunities. At those stations where an ITTP (Interdisciplinary Team Training Program) is in place, HBHC serves as a clinical setting for stipend students and the resources of the ITTP benefit the HBHC team.

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CHAPTER 2. POLICIES AND PROCEDURES

2.01 HBHC HOSPITAL POLICY MEMORANDUM

A Hospital Policy Memorandum which outlines the requirements, policies and procedures necessary for the operation of the HBHC program should be developed by the team, approved by the HBHC Advisory Committee and issued by the medical center Director. Delegation of authority to the HBHC Program Director, organizational placement of the program, lines of authority, scope of program services, referral procedures, admission and discharge procedures are among the elements that should be included in this memorandum.

2.02 HBHC ADVISORY COMMITTEE

An advisory committee is designated by the VA medical center Director and Chief of Staff to assist the HBHC team in the implementation, development and maintenance of the program. The functions of the HBHC Advisory Committee are outlined in a Hospital Policy Memorandum. In most medical centers, the HBHC Advisory Committee is composed of the Chiefs of the clinical services represented in the HBHC program.

2.03 THE HBHC POLICY AND PROCEDURE MANUAL

a. A policy and procedure manual is developed by the HBHC team to define and govern the clinical and administrative aspects of the program at their medical center. This manual should be a viable document that reflects current practice of the team. It should be reviewed and revised as necessary by the team but no less frequently than once a year. This manual should be reviewed and approved by the HBHC Advisory Committee and the medical center's Chief of Staff and Director.

b. JCAHO Home Care Standards for Accreditation specify the elements required in the policy and procedure manual. Some of these elements are detailed in the following paragraphs.

2.04 HBHC PATIENT INFORMATION HANDBOOK

Each HBHC team will prepare a handbook to distribute to patients upon admission to the HBHC Program. This handbook should contain, at a minimum:

a. Names of HBHC team members and office telephone numbers.

b. An explanation of the HBHC program, its capabilities and limitations.

c. HBHC patients' rights and responsibilities including grievance process.

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d. Specific instructions regarding the care of the patient during and after the regular hours of operation of the HBHC program.

e. Procedures to follow in the event of an emergency.

f. Charges for services, if applicable, in accordance with the MCCR (Medical Care Cost Recovery) policies.

2.05 HBHC PATIENTS RIGHTS AND RESPONSIBILITIES

Patients in the HBHC Program have the same rights and responsibilities as other patients in the VA system. HBHC Patients Rights and Responsibilities (app. A) may be

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given to patients and/or their caregivers. Every effort is made to ensure that the patients understand and exercise their rights and responsibilities in relation to their own care. In the event that the patient lacks decision-making capacity (as determined by the team physician), a proxy decision maker will be identified.

2.06 ADMISSION GUIDELINES

Guidelines for admission of patients to the HBHC program are:

a. Patient is eligible for VA outpatient care.

b. Patient lives within program service area. Boundaries are designated by each medical center.

c. Patient care needs can be met by HBHC program.

d. Patient has an identified caregiver.

e. Patient is homebound.

f. Patient has a multi-faceted disease process which necessitates care by an interdisciplinary team.

g. Patient and/or caregiver accept HBHC as the principal care provider.

h. The patient's home environment is safe for the well-being of the patient, caregiver and the HBHC team members.

2.07 FUNCTIONS OF THE HBHC PROGRAM DIRECTOR

a. The VA medical center Director and Chief of Staff designate the HBHC Program Director. The HBHC Program Director will be a health care professional with demonstrated ability and competence both in patient care and program administration.

b. The VA medical center Director delegates the management of the program to the HBHC Program Director. This includes planning, directing, budgeting, monitoring and evaluating the program.

c. The HBHC Program Director directs the clinical services offered by the program so as to ensure that the program is in compliance with the JCAHO Standards for the Accreditation of Home Care, and VA medical center and Central Office policy.

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d. The Program Director is responsible for the development and continued effective functioning of the interdisciplinary health care team. Understanding of the skills and knowledge of each team member and the contribution each makes to accomplish patient and program goals is of utmost importance.

e. The provision of administrative direction and team leadership includes:

(1) Interpreting national HBHC and local VA policy to the HBHC team and the medical center,

(2) Assisting the team in developing local HBHC policies and procedures and coordinating the provision of Quality Assurance, Utilization Review and Risk Management programs;

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(2) Evaluating the effectiveness of the HBHC program;

(4) Selecting qualified personnel to fill HBHC personnel vacancies;

(5) Coordinating the orientation and ongoing HBHC staff and student educational programs; and

(6) Monitoring and controlling program operation expenditures and monitoring and reporting the HBHC workload.

2.08 THE INTERDISCIPLINARY TEAM

a. Because of the diverse array of professional services required to effectively treat and manage the multiple health problems of chronic or terminally ill patients, HBHC care is best rendered by an interdisciplinary team. This team develops an identity which promotes communication and coordination among team members. The HBHC team members share common goals, collaborate and work interdependently in planning, problem solving, decision-making, implementing and evaluating team related tasks.

b. HBHC is a long-term care program; therefore, a variety of health care professionals is necessary to meet the needs of the patient population. The professional disciplines represented on the HBHC team are physician, nurse, social worker, rehabilitation therapist, pharmacist, and dietitian. A secretary is also essential to this program.

c. In addition to appropriate professional credentials, all HBHC staff should possess certain qualifications unique to the practice setting and the population served and are committed to:

(1) Discipline-specific standards of practice;

(2) The primary health care delivery model;

(2) Long-term care of a community-based patient population characterized by health problems that are secondary to chronic illness, interacting medical diagnoses, aging and terminal illness; and

(4) A holistic framework of practice.

d. An ability to effectively function both autonomously as well as a member of an interdisciplinary team.

e. A clinical background which includes demonstrated competency in assessment, problem solving, community practice and teaching.

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2.09 FUNCTIONS AS A MEMBER OF THE INTERDISCIPLINARY TEAM

Activities which demonstrate the team related functions are:

a. Participating in the establishment and review of the goals of the local HBHC program.

b. Determining appropriateness of patients for acceptance for HBHC care.

c. Developing interdisciplinary team treatment plans based on comprehensive assessment of the patient and the caregiver.

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d. Mutual follow-through with the care outlined on the patient's treatment plan through regular home visits.

e. Reviewing the patient's progress at regular intervals or when there is a change in the patient's condition.

f. Monitoring the caregiver's functioning.

g. Teaching the patient and the caregiver.

h. Collaborating formally and efficiently with the other team members throughout the process of care.

i. Determining the patient's continuing need for HBHC care.

j. Planning for discharge of patients from HBHC care.

k. Documenting all patient care activities in a timely manner.

l. Determining the need for continuing education and implementing in-service training of team members.

m. Defining areas for continuous monitoring of the quality of care provided and participating in the evaluation process.

n. Teaching students of various disciplines regarding the problems encountered in furnishing health care in the home setting, team functioning and the objectives of the HBHC program.

o. Developing and revising the local HBHC Policy and Procedure Manual.

2.10 FUNCTIONS OF THE HBHC TEAM MEMBERS

a. The HBHC Medical Director is appointed by the Chief of Staff. This physician is responsible for the medical care delivered by the HBHC team. The HBHC Medical Director assumes primary medical responsibility for all the patients on the HBHC program. The physician is responsible for identifying the patients' medical problems; defining the medical management of these problems; determining the need for consultation from medical/surgical/psychiatric subspecialty clinics; and determining the need for admission to the hospital. The physician is also responsible for planning and directing the educational and clinical experience of medical students, residents and fellows assigned to the HBHC program. As the physician is usually part-time, some clinical services are performed by the physician and others are delegated to other team members so clinically privileged. The physician attends HBHC team meetings and

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is always available to the team members for collaboration when medical or other problems arise.

b. The HBHC Nurse is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Nursing Service. The HBHC Nurse frequently functions as care manager linking the patient and the caregiver with the various health services offered by the HBHC team and the medical center. Patients are usually divided among HBHC nurses by geographic distribution. The nurse is responsible for: initial and continued assessment of unique nursing needs of the patient and caregiver; teaching the patient and caregiver effective and efficient ways of managing and delivering nursing care in the home; monitoring the patient's condition and the care provided in the home; supervising any

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LPNs or Home Health Technicians and/or nursing students assigned to the HBHC program. If appropriately credentialed, the HBHC Nurse frequently functions in the expanded nursing role and provides selected medical services.

c. The HBHC Social Worker is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Social Work Service. The HBHC Social Worker is responsible for the initial and continued assessment of the interpersonal resources and psychosocial functioning of the patient, the caregiver and their support system and the identification of problems. The social worker provides psychosocial treatment which may include individual and family counseling, and other specific therapies. The social worker coordinates discharge planning for HBHC patients including nursing home placement under VA contract or through other funding mechanisms and the effective use of VA and community resources. The social worker supervises the social work students assigned to the HBHC program and is responsible for teaching the impact of psychosocial problems on illness to students of other disciplines. If the program utilizes volunteers, the social worker usually trains and supervises these volunteers.

d. The HBHC Dietitian is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Dietetic Service. The HBHC Dietitian is responsible for the initial and continued assessment of the patient's nutritional status as well as the adequacy of the home caregiver's capacity to prepare recommended meals; and training the patient and the home caregiver in efficient and effective ways of managing the identified nutritional problems. The HBHC dietitian supervises the dietetic students and interns assigned to the HBHC program.

e. The HBHC RMS (Rehabilitation Medicine Service) Therapist is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Rehabilitation Medicine Service. The HBHC RMS Therapist is responsible for the initial and continued assessment of the patient's functional status and safety; an evaluation of the patient's home for needed structural modifications to make the home environment safe and accessible; determining the need for prosthetic equipment; teaching and monitoring the safe use of these devices; reporting equipment problems to the Prosthetic and Sensory Aids Service; teaching the caregiver body mechanics to minimize risk of injury; and establishing a therapeutic program for the patient and caregiver to maintain or enhance function or retard deterioration in the patient's functional status. The RMS therapist is also responsible for the supervision of RMS therapy students assigned to the HBHC program. Since the therapist may be an occupational therapist, physical therapist or kinesiotherapist there may be times when consultation with other RMS disciplines may be needed to solve specific patient problems.

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f. The HBHC Clinical Pharmacist is selected jointly by the HBHC Program Director, HBHC Medical Director and the Chief, Pharmacy Service. The HBHC Pharmacist is responsible for the initial and continuous monitoring and assessment of drug therapy. The clinical pharmacist identifies patient-specific medication issues, including drug interactions, adverse affects, efficacy, appropriateness, and compliance problems. He/she educates the patient and caregivers in the home about the proper use of medications. The pharmacist participates in HBHC patient care conferences and makes recommendations for medication regimen changes. The pharmacist provides drug information to other health care professionals. The HBHC Clinical Pharmacist is responsible for the supervision of pharmacy students or residents assigned to the program.

g. The HHT (Home Health Technician) is selected jointly by the HBHC Program Director, HBHC Medical Director and Chief, Nursing Service. The HBHC HHT is

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responsible for providing services to patients in their homes such as catheterizing, suctioning, changing dressings, providing tracheostomy care and other nursing procedures which may include personal care services. The HHT provides services alone and is accompanied only occasionally to the home by the HBHC nurse. The HHT may function in an expanded role and be involved in reinforcing rehabilitation measures with the patient/caregiver; demonstrating and teaching the use of therapeutic and rehabilitative devices such as lifts and walkers; monitoring and observing the patient's nutritional, psychological and physical status; and documenting evidence of pain, edema, depression and other signs and/or symptoms.

h. The Program Secretary is selected and supervised by the HBHC Program Director. The Program Secretary is responsible for the smooth daily operation of the HBHC office and serves as an administrative assistant to the Program Director. All incoming calls from HBHC patients, families and medical center staff are received and assessed for urgency by the secretary and referred to the appropriate HBHC team member in the office or in the field. The secretary is responsible for scheduling all clinic appointments; arranging and coordinating patient travel; for facilitating issuance of prosthetic equipment and pharmaceuticals; and maintaining records of laboratory tests conducted. The secretary is accountable for all records pertaining to the program and for maintaining and controlling the clinical and administrative records of all active HBHC patients. All statistical reports and cost accounting data are compiled and prepared by the secretary for the medical center Director and also for use in QA studies and evaluations of program operation and management.

2.11 PROCESS OF CARE

a. Referral. Patients are referred to HBHC from many settings, including inpatient, outpatient, nursing homes, etc., usually by consultation. The referred patient's problems and health care needs, the home caregiver and the home environment are evaluated by the HBHC team. If the patient and the home situation are found to be appropriate, the patient is accepted in the HBHC program. If the patient is not found to be appropriate, the HBHC team makes recommendations regarding an alternate plan for managing patient's care needs.

NOTE: Generally, starting a new program involves several of the team members in patient selection and orientation but as a team matures these responsibilities may be assigned to one member at a time for more efficient staff utilization.

b. Informed Consent. The accepted patient and caregiver are oriented to HBHC. A full explanation of the program, its objectives, capabilities and limitations is provided to the patient and the caregiver. The counseling of the patient is documented in the patient's medical record as well as the patient

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and/or caregiver's response to the explanation. The documentation by the health professional of this exchange of information constitutes informed consent of the patient to participate in the HBHC program.

c. Assessment of Patients. After admission to the program, the patient receives a comprehensive and timely assessment by each member of the HBHC team. The initial visit by the nurse is primarily for the purpose of identifying any unique nursing needs of the patient and the home caregiver. The HBHC physician assesses the patient's medical status in preparation for the development of the treatment plan. The social worker visits the home to assess the patient and the home caregiver's psychosocial strengths and weaknesses as well as the adequacy of the formal and informal social support system. The RMS therapist visits the home and assesses the patient's functional status, evaluates

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safety hazards and the need for adaptive equipment and structural modifications. The dietitian also visits the home and assesses the patient's nutritional problems, and the caregiver and home's suitability for the preparation of special diets.

d. Treatment Planning. Following the initial assessment of new patients by the different disciplines, the HBHC team holds a formal team meeting to develop the patient's interdisciplinary treatment plan. At these weekly team meetings the team works collaboratively and interdependently under the direction of the HBHC Medical Director. The treatment plan for each patient consists of a problem list of all problems identified by the members of the team, medication profile, measurable objectives with specific methods including the team member responsible for achieving the objectives. All team members responsible for the patient, including the HBHC physician, sign the treatment plan.

NOTE: The patient's treatment plan is developed by the HBHC team members, is individualized to each patient/caregiver, and constitutes physician's orders for care. Participation of the patient/caregiver in the development of the treatment plan is essential.

e. Delivery of Care. Having assessed patient needs and determined individualized goals of care through the formulation of the treatment plan, the team's major effort is to promote a therapeutic environment in the home. Frequency of home visits is determined by patient needs, staff resources, and program policies.

NOTE: Since HBHC teams are responsible for providing primary care to persons with complicated health problems, considerable attention must be given to the education and training of patients and caregivers. The caregiver is responsible for the routine care administered to the patient between HBHC staff home visits. In the event that the home caregiver cannot provide all of the needed care, the HBHC team can assist in accessing community and/or VA resources. The HBHC team members monitor and document therapeutic outcomes to ensure continuity of care.

f. Treatment Plan Reviews. The interdependence of the HBHC team members is maintained through progress notes documenting visits and formal reviews of the patient's treatment plan. The plan is reviewed and modified by the team as the condition of the patient changes, but no less frequently than every 90 days. Each weekly team meeting is divided between the staffing of new patients and the review of the patients' progress in reaching treatment objectives.

g. Discharge from HBHC. The decision to discharge a patient is made by the team based on the attainment of the established treatment goals and upon the continued appropriateness of the patient for HBHC services. Reasons for

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patient's discharge from HBHC are documented in the discharge summary. This summary will also include date of discharge, name of care provider to which the patient is being referred, if applicable; the status of problems identified at admission; the overall status of the patient at discharge and a summary of care provided including length of care and services provided. The patient and the caregiver are expected to participate in the discharge planning process.

2.12 DISCHARGE GUIDELINES

a. The HBHC team will facilitate timely and orderly discharges of patients who no longer need the services of the HBHC program to other medical providers in the VA

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medical center or in the community, as appropriate. Alternative health care services appropriate to the needed level of care will be arranged prior to discharge from HBHC. Circumstances under which patients will be discharged from HBHC include:

(1) Patient died.

(2) Patient is admitted to a hospital for 16 days or longer.

(2) Patient is admitted to VA Nursing Home Care Unit other than for respite.

(4) Patient is admitted to a nursing home in the community.

(5) Patient has reached maximum benefits from the program.

(6) Patient's care needs exceed the capability of the HBHC program and thus necessitate a referral to another home care agency.

(7) Patient and/or caregiver request discharge from the HBHC program.

(8) Patient and/or caregiver are non-compliant with the treatment plan and non-compliance is documented in the patient's medical record.

(9) Patient's home environment is no longer safe for the patient/caregiver or for the HBHC team members.

b. The HBHC team should furnish information about the medical status of the patient and work closely with the staff of the VA medical center to assure a smooth transition. The HBHC discharge summary should be written in a timely manner so that continuity of care is maintained.

c. Should the nursing home level of care become necessary for the patient who was admitted to HBHC following a period of VA hospitalization, the patient may be admitted directly to a community nursing home under VA contract. The patient is then discharged from the HBHC program on the date of nursing home admission.

2.13 AFTER OFFICE HOURS COVERAGE

Each HBHC program will have a policy providing for the care of patients at other than the regular hours of operation of the program. HBHC patients and their caregivers will be given, verbally and in writing, specific instructions about how to access care at all times (during and at other than the regular hours of operation of the program). Some HBHC programs have established 24-hour coverage, others refer patients to specific units at the medical center, and

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some advise patients to report to the medical center's Emergency Room if problems arise after office hours.

2.14 ADMISSION OF HBHC PATIENTS TO VA MEDICAL FACILITIES

When admitted to HBHC, the patient and caregiver are given assurance that admission to a VA facility may be accomplished at any time it is professionally indicated. Patients who are hospitalized 15 days or less may remain enrolled in HBHC. These patients should be placed in Absent-Sick-In-Hospital status. Those HBHC patients admitted to a Nursing Home Care Unit solely for the purpose of providing respite care may be placed in Absent-Sick-in-Hospital status. Information about the course of care in the home should

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be furnished to inpatient and nursing home staff. While hospitalized, the HBHC team should provide follow-up contacts with the patient and the caregiver. Upon release from the hospital or nursing home care unit, follow-up home visits may resume without a change in HBHC status. When patients are hospitalized 16 days or more they should be discharged from the HBHC program.

2.15 COOPERATION, COLLABORATION AND CONSULTATION WITH OTHER SERVICES

a. The HBHC team regularly cooperates and collaborates with the ancillary services to obtain needed services and procedures for the HBHC patients. Laboratory Service will advise on proper handling and storage of specimens collected in the home as well as accommodate HBHC patients for procedures which cannot be done in the home. Radiology and Nuclear Medicine provide services to HBHC patients on scheduled and unscheduled bases. HBHC physician and nurses work closely with the Pharmacy over the provision of medications and supplies to HBHC patients. Collaborative arrangements at many medical centers have resulted in clinical pharmacists working closely with HBHC teams to improve prescribing habits, treatment planning and patient education. Engineering Service can enhance the HBHC team's ability to identify and advise on fire and safety problems. The Prosthetic and Sensory Aids Service may provide support to HBHC patients by assisting in the delivery and maintenance of home medical equipment, as well as the instruction of patients and/or caregivers in the proper use of home medical equipment, either directly or through contracted organizations or individuals.

b. As HBHC accepts referrals from the various units and services of the medical center collaborative relationships will develop to foster continuity of care. Furthermore, the specialty services are medical center resources available through consultation to the HBHC team when medically indicated. Such relationships and resources serve to enhance HBHC's capacity to manage complex patients in the home setting. Should the home placement begin to falter or fail, such relationships will facilitate the orderly readmission of the patient to the appropriate service for further care.

c. The health problems of the HBHC patient population often include mental health components (ref. par. 4.04). A liaison with Psychiatry and Psychology Service should be sought to facilitate the assessment and treatment of these problems. An ongoing consultive relationship should include a continuing education program for the team members, consultation regarding assessment and treatment of individual patients or family members, and indications and procedures for obtaining direct mental health treatment.

d. At the outset, the HBHC team should also develop relationships with pulmonary medicine, oncology, urology, geriatrics, neurology, orthopaedics, and other medicine and surgery subspecialties which seem appropriate. Senior

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clinicians from these specialties, in addition to offering opinions on specific patients, may be willing to assist HBHC programs in developing protocols for their specialty areas.

2.16 ORIENTATION AND CONTINUING EDUCATION OF HBHC TEAM MEMBERS

The orientation of new HBHC team members should ensure understanding of the goals, objectives,and procedures utilized by the HBHC Program. The HBHC Policy and Procedure Manual usually serves as the basic orientation guide. Both the orientation and continuing education program of HBHC team members should regularly address infection control in the home, basic home safety, emergency preparedness and HBHC patients

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rights and responsibilities. In addition, all HBHC team members are responsible for maintaining their discipline's continuing education requirements for licensure/ certification.

2.17 VOLUNTEER SERVICES

Several HBHC programs utilize volunteers through the VA Voluntary Service, the SCP (Senior Companion Program) and RSVP (Retired Senior Volunteer Program). Relationships with SCP and RSVP have been formalized through an inter-agency agreement between VA and ACTION, the federal domestic volunteer agency. HBHC volunteers are selected, trained and supervised by the HBHC team. Volunteer services provided by other than VA Voluntary Service require an inter-agency agreement.

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CHAPTER 3. PATIENT CARE ISSUES

3.01 SAFETY ISSUES

a. The safety of the HBHC patient, the caregiver, the home environment, and the HBHC team members should be carefully addressed by all HBHC programs.

b. An assessment of the patient's home environment to identify safety hazards that could result in injury to the patient and caregiver will be performed and documented upon admission of the patient to the HBHC program. Appropriate steps to reduce or minimize the risks to the patient, home caregiver and HBHC team members should be instituted by the HBHC Team or recommended to the patient and home caregiver for action. Monitoring of the patient, home caregiver and team members' safety should be an on-going process for as long as the patient is in the HBHC program.

c. Each HBHC program will have a system of documenting, evaluating and reporting accidents and injuries and for documenting safety hazards. The aggregate results of these evaluations will be considered during the review of the quality and appropriateness of patient care provided by the HBHC Team.

3.02 INFECTION CONTROL

a. Universal precautions to prevent the spread of infection and the U.S. Environmental Protection Agency guidelines for disposal of biohazardous waste in the home are an integral part of the HBHC patient and staff education and performance.

b. A system for documenting, evaluating and reporting all infections in the HBHC patient population will be monitored for trends and preventable factors. Infection control results and evaluations should be considered during the annual review of the quality and appropriateness of patient care. Aggregate results of the data will be reported to the appropriate medical center authority.

3.03 EMERGENCY PREPAREDNESS

Each HBHC program will have an emergency preparedness plan designed to provide continuing care and support to the patient in the event of an emergency that could result in an interruption of patient care services by the HBHC team. Natural disasters, civil disturbances, power outages, unplanned absence of staff or home caregiver, etc., need to be considered as they apply to individual patients. Patient and caregiver will be educated in emergency preparedness. A plan corresponding to these circumstances must be developed, monitored, and evaluated on a regular basis.

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3.04 MENTAL HEALTH ISSUES

While HBHC does not target psychiatric patients as its service population, many HBHC patients have concurrent mental health problems often including depression, anxiety, behavioral problems, or cognitive impairment. A consultation/liaison relationship should be established with Psychiatry and Psychology Services for the assessment, treatment and management of these problems. Within this relationship, in-service training sessions can be developed to hone skills in mental assessments and interventions and to increase knowledge of depressions, confusion, suicide threats or gestures, caregiver abuse, etc. Such sessions or individual consultation can be useful to team members in managing

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the patient and in developing strategies to avert a crisis in the home. The consultation/liaison relationship includes assessment and treatment of individual patients or family members, and indications and procedures for obtaining direct mental health treatment.

3.05 CRITICAL CARE PLANNING/DO NOT RESUSCITATE ORDER IN THE HOME

As part of each person's right to self-determination, every HBHC patient may accept or refuse any recommended medical treatment. It is recognized that the majority of HBHC patients have either a debilitating chronic disease or terminal illness and are faced with the need to make decisions about extraordinary life support measures. Each HBHC program will have a policy guaranteeing patients' right to make these decisions. Procedures outlined in each medical center's "Do Not Resuscitate Policy" should be examined and adapted to the care of patients in their homes.

3.06 MEDICATION USE IN THE HBHC PATIENT POPULATION

Medication management in the care of the elderly and chronically ill is an area which requires significant attention by the interdisciplinary team. Specific policies addressing selection and clinical evaluation of drugs for therapeutic appropriateness must be established to offset the high potential for side effects, polypharmacy and compliance problems in this population. In addition, procedures and protocols to guide the team in the delivery, instruction, storage, and monitoring of drugs must be developed with particular attention to the administration of parenteral, intravenous and nebulized medications in the home setting.

3.07 HOME MEDICAL EQUIPMENT

The JCAHO Home Care Standards for Accreditation relate to all home medical equipment including ambulation and bath aides; oxygen services; life-sustaining and/or custom electrical equipment; and intravenous pumps. Under these standards, the HBHC team is responsible for assessing and prescribing appropriate medical equipment for HBHC patients and for teaching the patient and caregiver the proper and safe use of the equipment. The team documents this assessment and instruction. Further, the team monitors the patient and refers any equipment related problems to the appropriate staff person. Prosthetic and Sensory Aids Service, and other services involved with the provision of home medical equipment, are responsible for meeting and ensuring that home equipment contractors meet all of the JCAHO Home Care Standards for Accreditation.

3.08 REFERRALS TO COMMUNITY SERVICES

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HBHC patients will be referred to community resources upon discharge from the HBHC program if needed to meet their continuing care needs. Relevant information is provided to the patient and/or family regarding the resources available to meet the identified needs so that they can be active participants in the planning of referral by the HBHC program. When the patient is referred for the services of another organization, relevant information is given to the proposed provider after obtaining a patient's release of information. In addition, referrals will be made when services needed by the HBHC patient are not provided by VA, such as home health aide care, homemaker, home-delivered meals or legal assistance. When supplementary services are to be provided to the patient by a community resource in conjunction with HBHC care, they will be coordinated with those provided by the team. VA is not responsible for payment of these services nor is any reimbursement received for referrals.

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3.09 RESPITE CARE

a. The provision of 24-hour continual care is stressful to family caregivers. A plan for providing caregivers with some type of intermittent, short-term respite may assist in reducing this stress, thereby, facilitating the care of the patient in the home. There are three generally recognized models of respite care:

(1) In-Home, e.g., personal care, chore service, professional nursing, paid or volunteer companion.

(2) Out-of-Home, e.g., adult day care, support group, or institutional care.

(3) Combination plan.

b. The VA Respite Care Program, an Out-of-Home model, is defined as a program of limited duration; is furnished in a VA medical center or Nursing Home Care Unit; and is for the purpose of helping the veteran to continue residing primarily at home. Some HBHC programs utilize volunteers for In-Home respite through the SCP (Senior Companion Program) and the RSVP (Retired Senior Volunteer Program).

3.10 CAREGIVER SUPPORT

a. HBHC considers the patient and the patient caregiver as the unit of care. Without the caregiver, the maintenance of the severely chronically ill in their homes would be an impossibility. Yet HBHC providers recognize that the burden of care can be very great with high social, psychological, physical and economic costs.

b. While HBHC cannot treat the non-veteran caregivers, HBHC team members can continually assess the well-being, functional capacity, and general health status of the caregiver. Recognition of the role of the caregiver, the unique stresses and strains of each caregiver's situation, and appropriate intervention to prevent the unnecessary breakdown of the caregiver/patient relationship are the responsibility of HBHC. Supportive home visits by the HBHC team members and VA and community programs designed for caregivers should be utilized to enhance the caregiver's coping ability.

3.11 BEREAVEMENT SERVICES

Upon the death of the veteran, visits to the surviving spouse or other significant individuals may continue for up to six months, if clinically

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indicated, to facilitate the bereavement process. The medical center Director may approve a longer period of time when medically indicated.

3.12 DEATH IN THE HOME

HBHC adheres to the Hospice philosophy and offers palliative and supportive services to the terminally ill patient. The goals are to help the terminally ill patient achieve maximum emotional well-being and freedom from physical pain; to keep him/her functioning at a maximal level so that he/she can live as fully as possible until death comes; to address any special needs of the patient and family members that arise from the stresses associated with the final stages of illness, dying and bereavement and to clarify the veteran's and family's wishes regarding life-sustaining efforts before death and procedures following death.

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CHAPTER 4. PROGRAM MONITORING

4.01 QUALITY ASSURANCE

a. A defined and functional QA (Quality Assurance) Program in all HBHC programs is mandatory. The process of monitoring, evaluating and problem solving is designed to help the HBHC program to appropriately utilize its resources to manage the quality of care it provides. The monitoring and evaluating activities are:

(1) Ongoing, planned, systematic and comprehensive;

(2) Designed so that data collection and evaluation are adequate to identify problems; and

(3) Designed to utilize effective problem-solving activities.

b. Each HBHC Program will write an annual QA plan and an annual evaluation of the effectiveness of the QA Program. This plan should be part of the medical center's total QA Program.

4.02 UTILIZATION MANAGEMENT

a. Appropriate utilization of resources is essential to the management of any health care program. Utilization management is accomplished in part, by identifying those resources that are both required and available to support program goals and objectives. The first step in utilization review, therefore, is to have clearly defined program goals and objectives. Patients are assessed prior to admission to HBHC to determine whether or not they require and will use the available resources. Patients have on-going, periodic assessments to evaluate the need for continued care. When the patient has received maximum benefits from the program or a different level of care is needed, discharge plans are implemented.

b. Components of a utilization management program for HBHC include, but are not limited to the following:

(1) Appropriateness of referrals to the program.

(2) Appropriateness of admissions to the program.

(3) Appropriateness of services rendered.

(3) Appropriateness of continued stay.

(4) Appropriateness of discharge from the program.

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c. In order to effectively implement an utilization management program within the HBHC program there are numerous databases which support and complement utilization management activities:

(1) PTF (Patient Treatment File),

(2) DHCP (Decentralized Hospital Computer Program),

(3) HBHC Information System,

(3) CDR (Cost Distribution Report), RCS 10-0141, and

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(4) Patient's medical record.

d. Utilization reviews should be conducted periodically. These reviews should include quarterly medical record reviews to assure that the medical records reflect the care provided, the condition and progress of the patient and the condition of the patient at discharge. The results of such reviews should be analyzed, documented, trended, and used to monitor practices so that the quality and efficiency of care may be improved.

4.03 RISK MANAGEMENT

a. The principles of risk management for hospitals apply equally to risk management for HBHC programs. Effective risk management emphasizes improving quality of care as opposed to solely reducing patient and staff injuries.

b. The concept of risk management applied to home care is relatively new, focusing initially on establishing policy to provide high quality care and extending to improving the skills of staff in the home care setting, preventing patient and staff injuries, and dealing with occurrences and incidents in a unique, less controlled environment. The principles of hospital risk management are applied in a new, if not broader and developmental context.

c. Essential elements in a successful HBHC risk management program are:

(1) Well-designed policies and procedures including a planned process for identifying high risk situations.

(2) Systematic recruiting, credentialing, privileging and training of home care staff.

(3) Training of patients and their families/caregivers in their home care responsibilities.

(4) Reporting and managing of incidents/occurrences.

(5) Analysis of incident/occurrence reports. This should be part of the on-going staff training and patient/caregiver education to achieve a progressive reduction of incidents, and reduction of liability risks.

4.04 HBHC INFORMATION SYSTEM

a. The HBHC program utilizes a computer-assisted system to collect a common set of data about its patients. The information gathered on multiple carbon set forms is used in patient care and in local and national program management, evaluation and reporting. The forms used in this Information System are:

(1) HBHC Evaluation/ Admission Form (VA Form 10-0014);

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(2) HBHC Discharge Form (VA Form 10-0014a);

(3) HBHC Visit Log (VA Form 10-0014b); and

(4) HBHC Correction Form (VA Form 10-0014c.)

It is important that all HBHC teams use the same definitions in completing the forms and instructions for the system are in the HBHC Information System Handbook.

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b. The information that is gathered is managed by the VA Data Processing Center in Austin, Texas. Monthly each program receives a listing of its admissions and discharges for the fiscal year to date. Quarterly, a number of reports are prepared for each program and for the HBHC program systemwide. Among these are compilations of patient characteristics, visits, diagnoses, disability levels and lengths of stay.

4.05 COST DISTRIBUTION REPORT, RCS 10-0141

HBHC reports costs under Account 5110 of the CDR (Cost Distribution Report), RCS 10-0141. Accurate and uniform input of data is required. The HBHC Program Director and the Chief, Fiscal Service are to work closely and collaboratively in the preparation of the data submitted. The responsibility for accurate distribution of costs is shared by Chief, Fiscal Service, other Service Chiefs and the HBHC Program Director. Instructions for preparation of the HBHC Account 5110 are included in the CDR handbook.

4.06 WORKLOAD STANDARDS

All HBHC programs are assigned a minimum workload by VA Central Office. An average daily patient census and a minimum number of monthly visits by the team are assigned according to the staffing of each HBHC team.

4.07 SCHEDULING

HBHC is an outpatient program and as such reports patient visits in the same manner as an outpatient clinic. Procedures for collecting and submitting data vary among medical centers and may be via completion of the Outpatient Routing and Statistical Record or by direct computer entry by clinical programs. A report for tracking outpatient visits and procedures is submitted monthly by each medical center's MAS (Medical Administration Service) to the VA Data Processing Center. All HBHC programs are responsible for coordinating with MAS and submitting data on outpatient visits according to individual medical center procedures.

4.08 RESEARCH and SURVEYS

a. HBHC is a setting which offers unique opportunities to study and evaluate health care and the delivery of services to a chronically ill patient population in their homes. All research studies must be approved through appropriate VA channels. The process involves seeking approval from the medical center's research committee and may require the approval of the human studies sub-committee of the affiliated university. At the smaller VA facilities that do not have a research committee, the Chief of Staff should be consulted. There are regional research committees that can be accessed.

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b. Locally initiated surveys of activities by HBHC programs should be coordinated with the VA Office of Geriatrics and Extended Care.

4.09 MISCELLANEOUS

In addition to the HBHC Information System and Cost Distribution Reports, mechanisms for record keeping must be maintained for MAS as well as various programmatic reports such as annual reviews (medical centers, Sections, Services), advisory committee meetings and management briefings. The content and form of reports may vary according to the local requirements of a particular medical center.

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APPENDIX A

HBHC PATIENTS RIGHTS AND RESPONSIBILITIES

AS A PATIENT IN THE HBHC PROGRAM YOU HAVE THE RIGHT TO:

1. Be cared for with respect and kindness.

2. Be told about your health problems.

3. Be told how your health problems are usually treated.

4. Be told what you can expect from treatment.

5. Agree to your treatment.

6. Refuse any part of your treatment.

7. Be told what will happen to you if you refuse any treatment.

8. Privacy. No one except the Court can find out about your health programs unless you give written permission.

9. Refuse to take part in any research studies.

10. Complain if you feel your rights have been denied.

11. Be discharged from the HBHC program at any time you wish.

AS A PATIENT IN THE HBHC PROGRAM YOU HAVE THE RESPONSIBILITY TO:

1. Treat the HBHC team with courtesy and respect.

2. Ask questions about any part of your care that you do not understand.

3. Tell the HBHC Team about any changes in your condition or in how you feel.

4. Tell the HBHC Team about other health problems you have had in the past.

5. Tell the HBHC Team about all medicines and remedies you are using.

6. Follow the HBHC Team's instructions.

7. Let the HBHC Team know if you are having problems following any instructions.

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8. Let the HBHC Team know if you decide not to follow some of the Team's instructions.

Adapted from:

1. VA Form 10-7991a, July 1983. Welcome to your VA medical center Information Booklet on Patients Rights and Responsibilities.

2. The National Association for Home Care: Patient Rights & Responsibilities. Continuing Care, May 1987, page 17.

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APPENDIX A

DERECHOS Y RESPONSABILIDADES DE LOS PACIENTES EN EL PROGRAMA DE CUIDADO MEDICO EN EL HOGAR (HBHC)

Como paciente en el Programa de Cuidado Medico en el Hogar (HBHC) Usted tiene derecho:

1. A que se le trate con respeto, cortesia y amabilidad.

2. A que sus problemas de salud se le expliquen de manera que Usted los puede entender.

3. A que se le diga cual es el tratamiento medico indicado.

4. A que se le expliquen los posibles resultados de ese tratamiento.

5. A dar su consentimiento para ese tratamiento.

6. A negarse a seguir el tratamiento o cualquier parte del tratamiento.

7. A que se le expliquen las consecuencias de no seguir el tratamiento medico indicado.

8. A privacidad. Nadie tiene derecho a obtener informacion sobre sus problemas de salud sin su permiso por escrito. Solamente la Corte puede ordenar al VA a dar informacion sobre los problemas de salud de los pacientes.

9. A negarse a tomar parte en una investigacion o estudio medico.

10. A quejarse si se le han negado sus derechos.

11. A ser dado de alta del Programa de Cuidado Medico en el Hogar (HBHC) si Usted lo desea.

Como paciente en el Programa de Cuidado Medico en el Hogar (HBHC) Usted tiene la responsabilidad:

1. De tratar al Equipo Medico de HBHC con cortesia y respeto.

2. De hacer preguntas sobre cualquier aspecto de su cuidado medico.

3. De decirle al Equipo Medico de HBHC si ha habido algun cambio en su estado de salud.

4. De decirle al Equipo Medico de HBHC cuales son sus problemas de salud, presentes y pasados.

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5. De hacerle saber al Equipo Medico de HBHC cuales medicinas o remedios caseros Usted toma y cuando los toma.

6. De seguir las instrucciones o recomendaciones del Equipo Medico de HBHC.

7. De decirle al Equipo Medico de HBHC si Usted tiene algun problema en entender o en seguir las instrucciones.

8. De expresar claramente sus deseos si Ud ha decidido no seguir las instrucciones del Equipo Medico de HBHC.

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APPENDIX C

REFERENCES

1. M-l, part I, chapter 30, Section II. HBHC (Hospital Based Home Care) addresses HBHC program policy.

2. M-1, part I, chapter 17, addresses policy for outpatient care, including outpatient eligibility.

3. M-l, part I, chapter 12, change 2, section III, addresses policy for contract nursing home placement of HBHC patients directly from their homes.

4. M-l, part I, chapter 5, addresses policy regarding HBHC medical records.

5. M-2, part I, chapter 30, change 81 addresses DNR (Do Not Resuscitate) protocols in VA medical centers.

6. M-2, Part IX, "Prosthetic and Sensory Aids Service," addresses policy for prosthetics and home medical equipment.

7. M-3, part I, chapter 3, change 1, addresses policy for research utilizing human subjects.

8. M-5, Part VII, "Extended Care Programs," chapter 1, addresses respite care policy.

9. 38 CFR Section 17.60 F(a), authorizes bereavement services.

10. 42 U.S.C. 1995 f(a)(b), provides the definition for the term "homebound" ("confined to his home").

11. 44 U.S.C. chapter 35, contains the authority and limitations of written surveys of the general public.

12. Manpower Policy for Primary Health Care: A Report of a Study. National Academy of Science, Washington, DC 1978. Defines the term "primary care."

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APPENDIX C

Department of Veterans Affairs M-5, Part V
Veterans Health Administration
Washington, DC 20420 November 29, 1991

1. Transmitted is a new part to the Department of Veterans Affairs, Veterans Health Administration Manual M-5, "Geriatrics and Extended Care," Part V, "HBHC (Hospital Based Home Care)," chapters 1 through 4 and Appendices A and B.

2. Principal purposes are:

a. Chapter 1: HBHC (Hospital Based Home Care) Program. Cites statutory authority, provides key program definitions and specifies facility staff responsibilities.

b. Chapter 2: Policies and Procedures. Establishes facility standards to be met and describes the process of care.

c. Chapter 3: Patient Care Issues. Clarifies selected patient care issues.

d. Chapter 4: Program Monitoring. Describes elements of program monitoring.

e. Appendix A: HBHC Patient Rights and Responsibilities is an example of the information which must be included in document given to patient/caregiver.

f. Appendix B: Derechos y Responsabilidades de los pacientes en el Programa de Cuidado Medico en el Hogar (HBHC).

g. Appendix C: List of references.

3. Filing Instructions

Remove pages	Insert pages
	1-i through 4-1
	Appendix A-1 through C-1

Signed 11/29/91

James W. Holsinger, Jr., M.D.
Chief Medical Director

Distribution: RPC: 1151 is assigned

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APPENDIX C
FD

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APPENDIX C

Department of Veterans Affairs M-5, Part V
Veterans Health Administration Change 1
Washington, DC 20420

November 3, 1992

1. Transmitted is a change to the Department of Veterans Affairs, Veterans Health Administration Manual M-5, "Geriatrics and Extended Care," Part V, "HBHC (Hospital Based Home Care)," Chapter 2, "Policies and Procedures," and Chapter 3, "Patient Care Issues."

2. Principal purpose of this change is to correct the part number from part VIII to part V to Chapter 2, "Policies and Procedures," and Chapter 3, "Patient Care Issues."

3. Filing Instructions

Remove pages	Insert pages
2-1 through 2-10	2-1 through 2-10
3-i through 3-3	3-i through 3-3

James W. Holsinger, Jr., M.D.
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